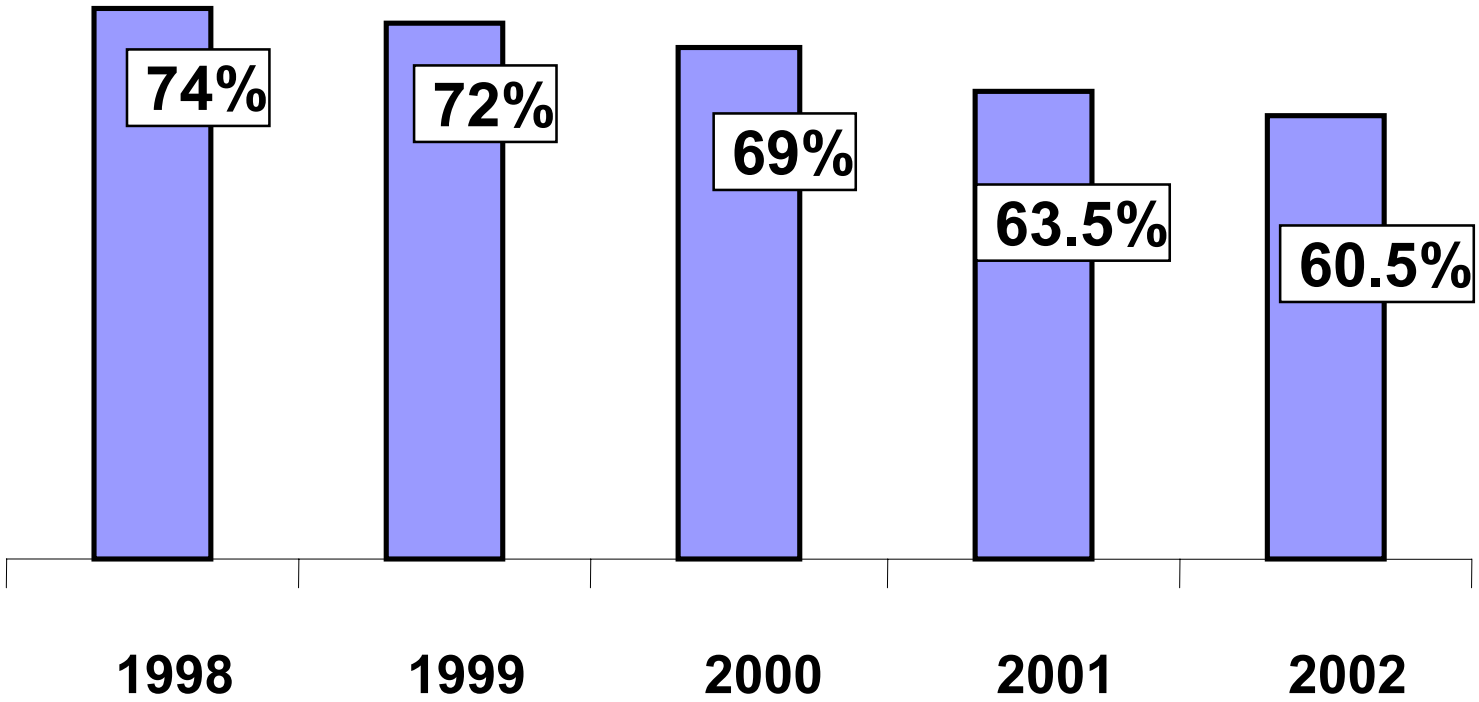
M+C Changes in Access, Benefits, and Premiums, 2001 to 2002

Major Trends in M+C for 2002

- *Access to Medicare+Choice coordinated plans will decline in 2002, but not as much as in the preceding year.*
- *Access to zero premium plans continues to decline. Charges incurred for specific services (e.g., deductibles and copayments) will rise, particularly among zero premium plans.*
- *Premium levels will rise, with about one third of current enrollees having to pay over $50 for a basic plan if they remain enrolled in their current plan.*
- *Access to M+C drug coverage will decline in the overall population. Three States (NJ, IL, LA) will see significant declines in access to drug coverage through M+C organizations. More M+C organizations will discontinue offering drugs as options that their enrollees can purchase for an additional premium.*
- *There will be a significant shift in drug coverage away from brand name coverage to coverage of only generic drugs.*

Access to M+C coordinated care plans (CCPs) declined as a result of 2001 non-renewal activity, but the decline in access was not as significant as in the preceding year.

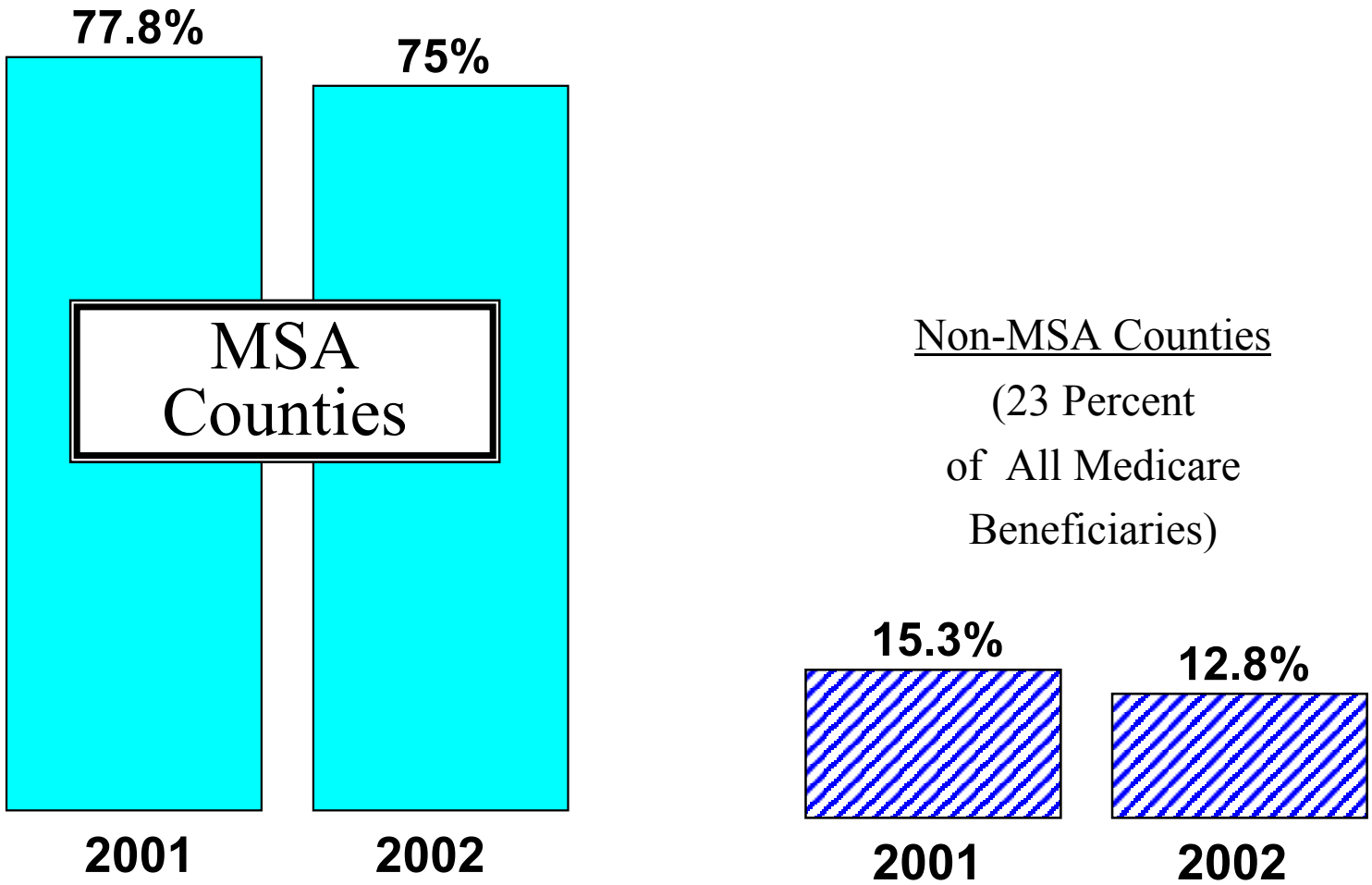
Percent of Overall Medicare Population in US with Access to at Least One M+C CCP Plan, 1998 to 2002



In 2001, an additional 18% of the Medicare population had access to M+C through Sterling, the private fee-for-service plan. In 2002, an additional 16% have access to Sterling as the only available M+C plan.

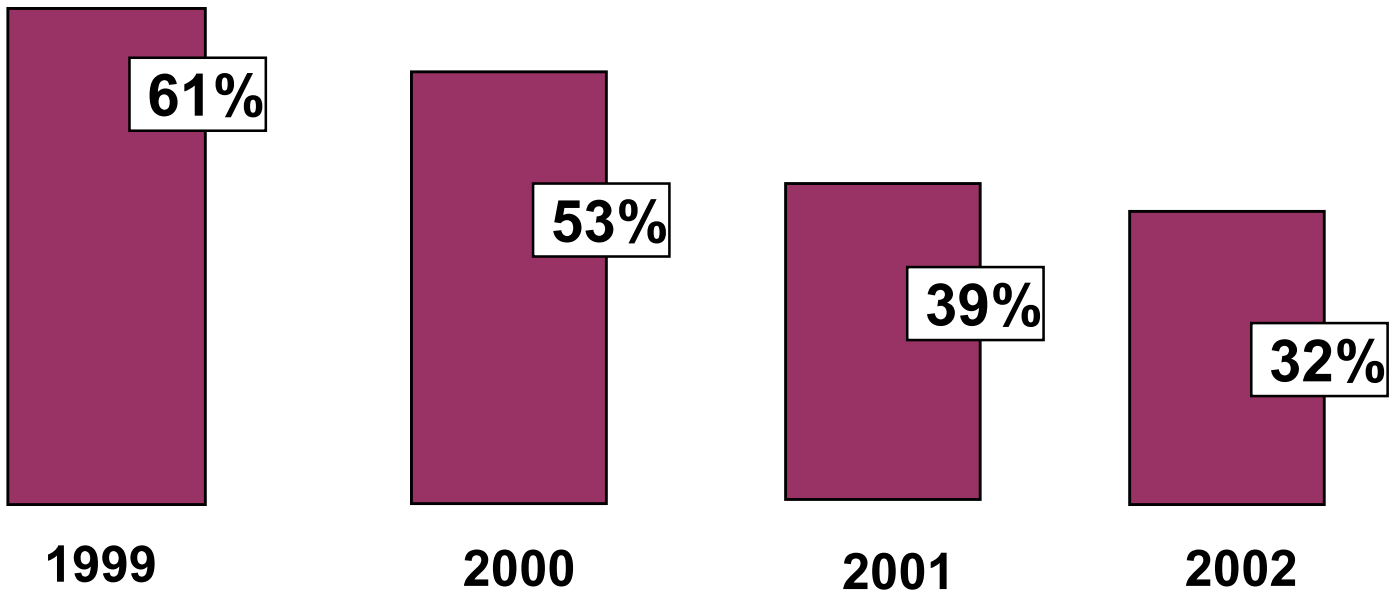
In both rural areas and urban areas, access will decline.

Change in Percent of Overall Medicare Population with Access to M+C CCP Plans, 2001 and 2002, MSA Versus Non-MSA Counties



Access to zero premium plans will decline in 2002, continuing a pattern of significant decline, particularly in 2001. In addition, as shown in the following charts, the benefit structure will change significantly among zero premium plans.

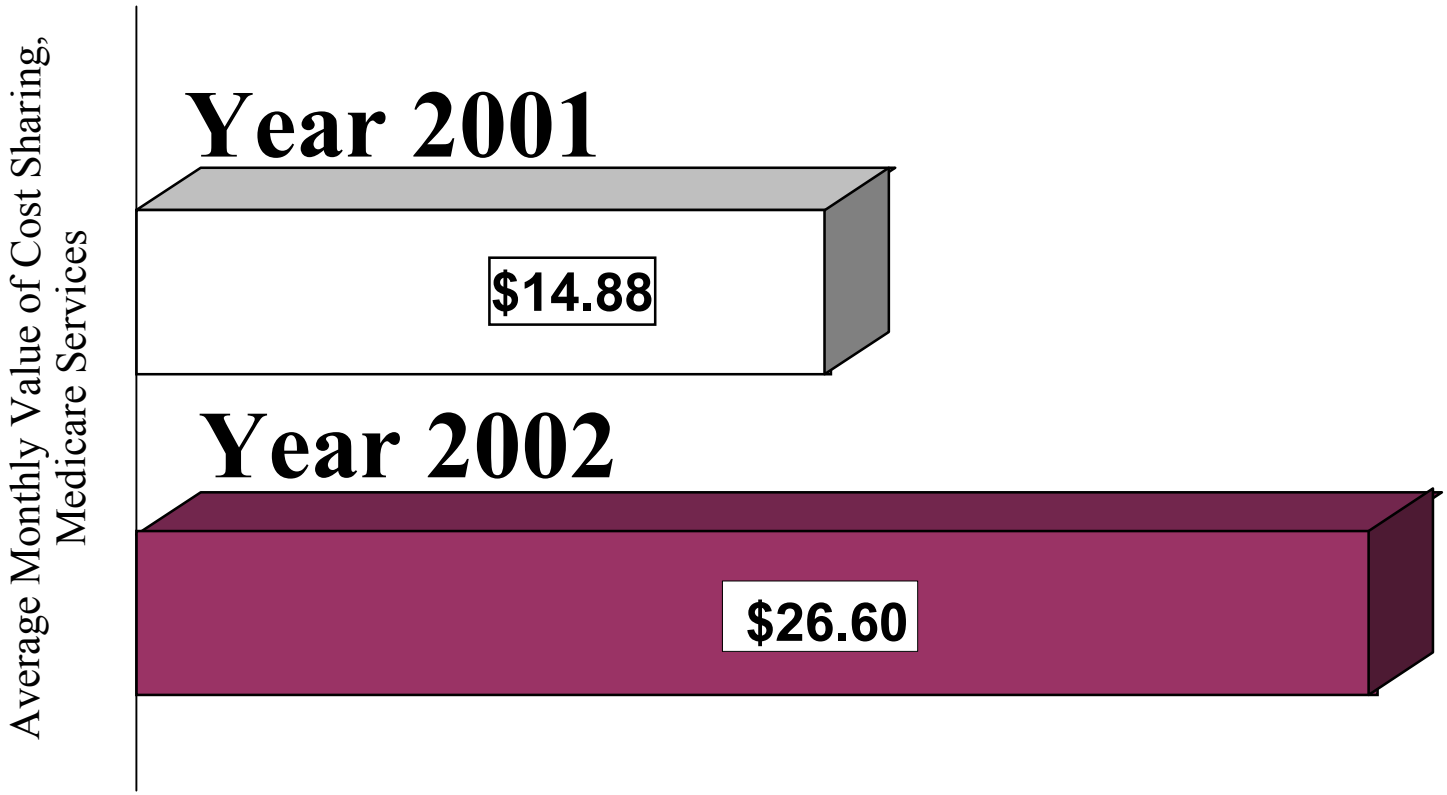
Percent of Overall Medicare Population in US with Access to Zero Premium M+C CCP Plans, 1999-2002



NOTE: See slide 9 for the distribution of enrollment by premium levels in 2001 and 2002. For 2001, 46 percent of M+C CCP enrollees (including both those affected by a non-renewal and affected enrollees) were in zero premium plans.

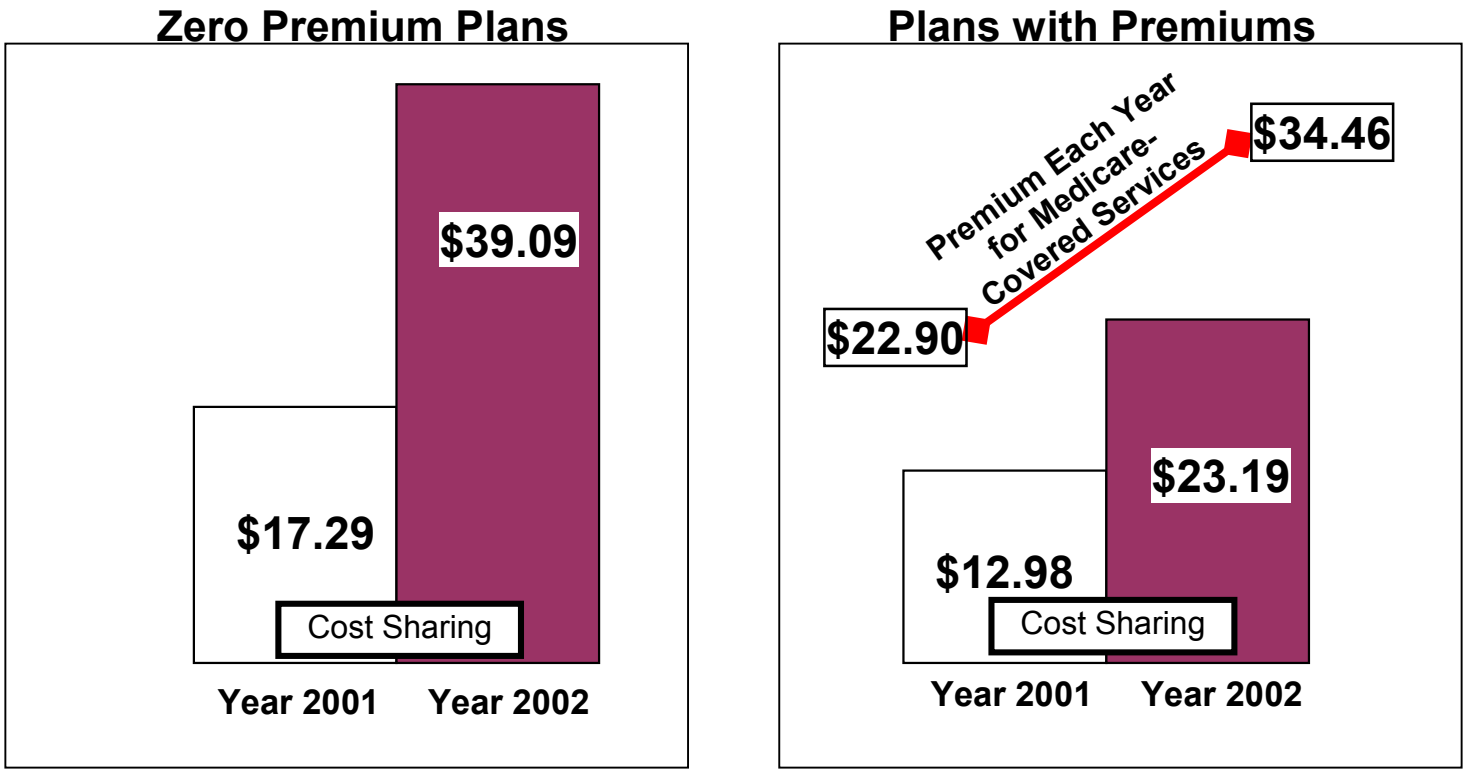
Charges incurred for specific services, in the form of copayments, deductibles and coinsurance, will rise significantly in 2002.

Enrollment-Weighted Average Monthly Value of Cost Sharing for Medicare-Covered Services, Per Enrollee Per Month, Current Enrollees Unaffected by Non-Renewals



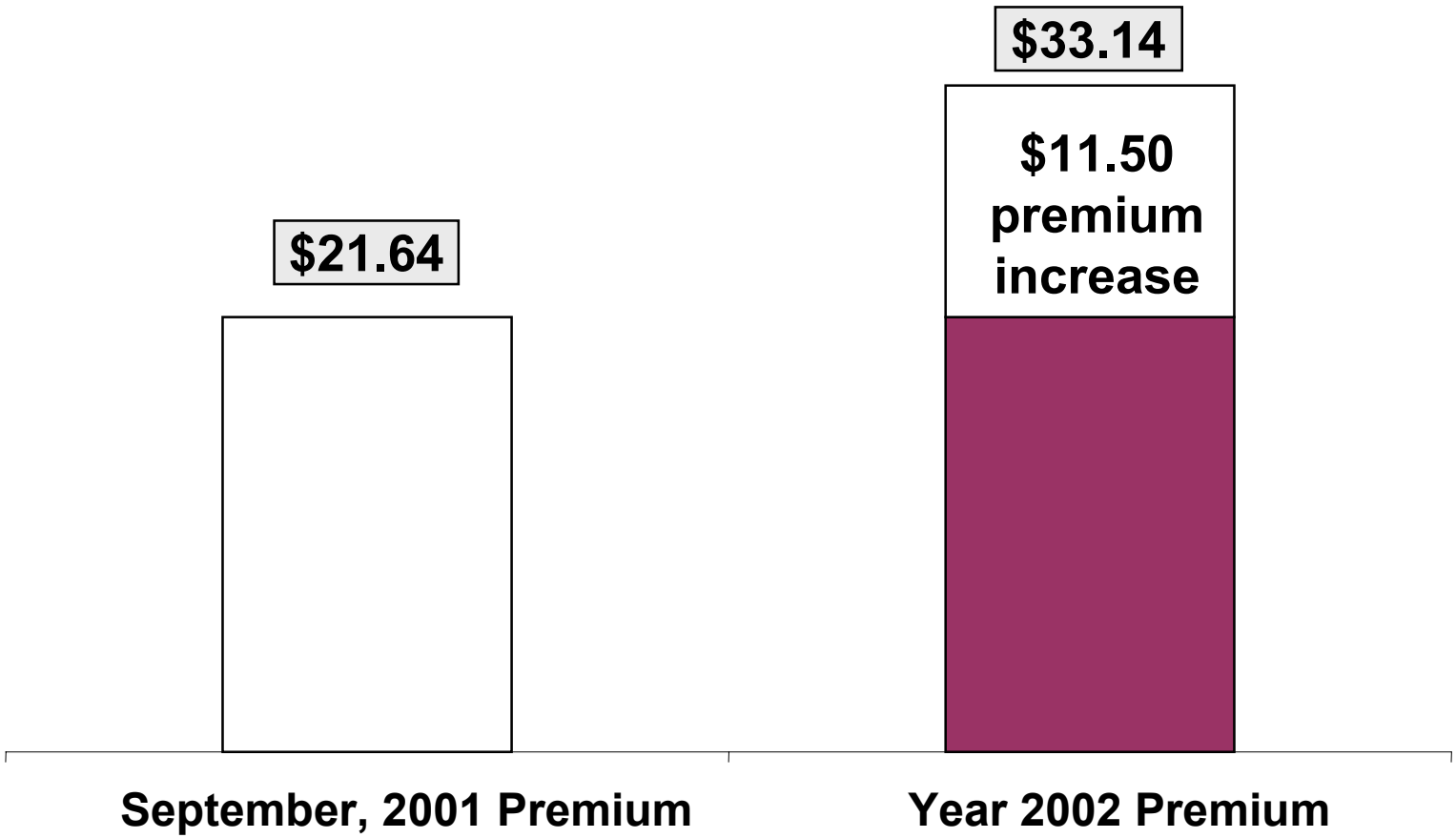
Plans that have no premium have higher average cost sharing charges. In 2002 the difference in such charges between zero premium plans and plans with premiums (about $16) will be significantly greater than in 2001 (when it was about $4).

Enrollment-Weighted Average Monthly Out-of-Pocket Cost Sharing for Medicare-Covered Services, by Premium Category, Enrollees Unaffected by Non-Renewals



Though premiums on average will remain relatively low in 2002, they will be significantly higher than in 2001.

Enrollment-Weighted Average Basic Premium, Enrollees Unaffected by Non-Renewals in 2001 Compared to Same Enrollees If They Remain in Current Organization in 2002

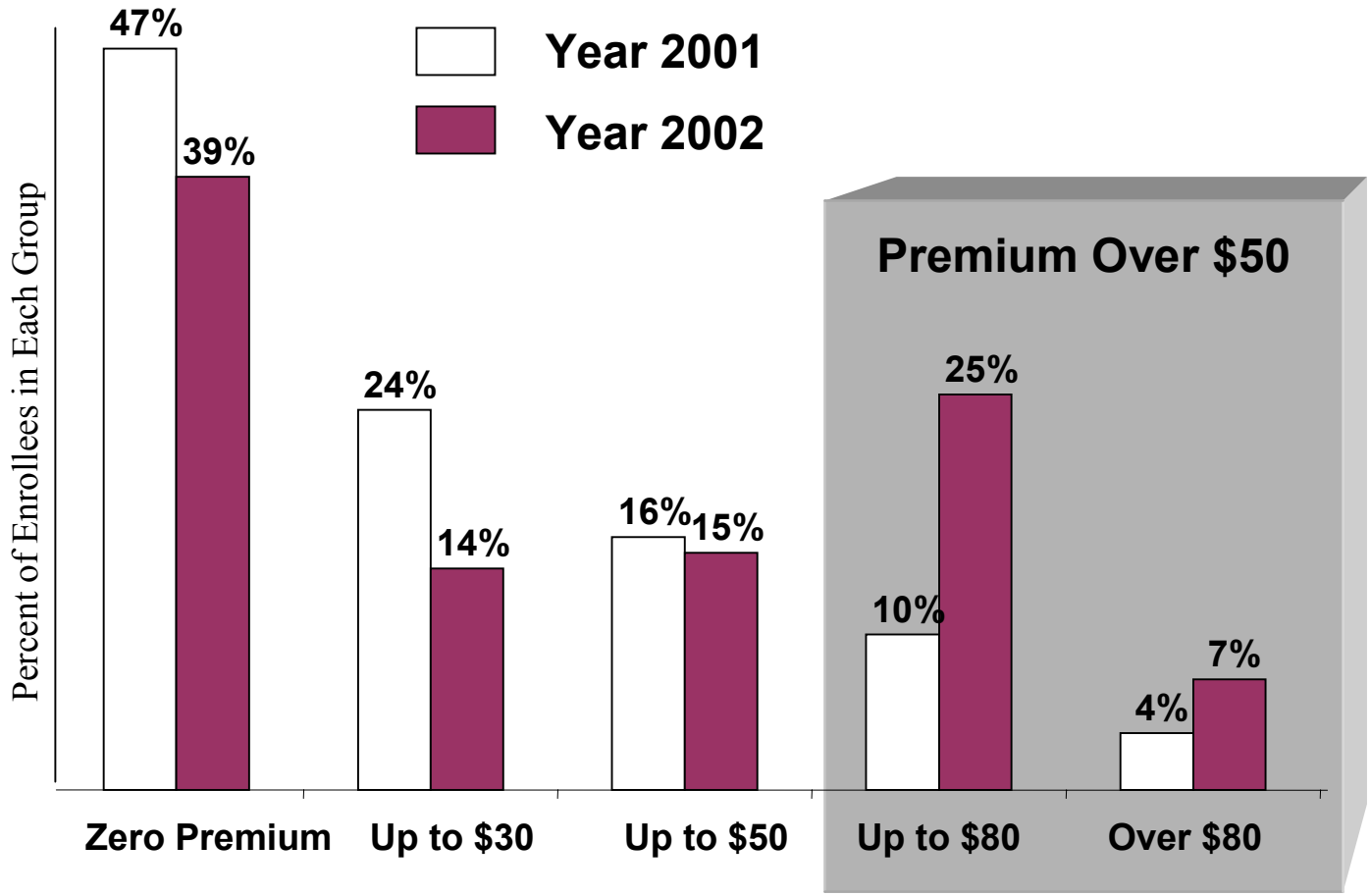


Year 2001 to 2002 Premiums

CMS CENTERS for MEDICARE & MEDICAID SERVICES

In 2002 nearly one third of enrollees (32 percent) will have basic premiums over $50, compared to 14 percent in 2001.

Basic Premium Ranges, Enrollees Unaffected by Non-Renewals in 2001 Compared to Same Enrollees If They Remain in Current Organization in 2002

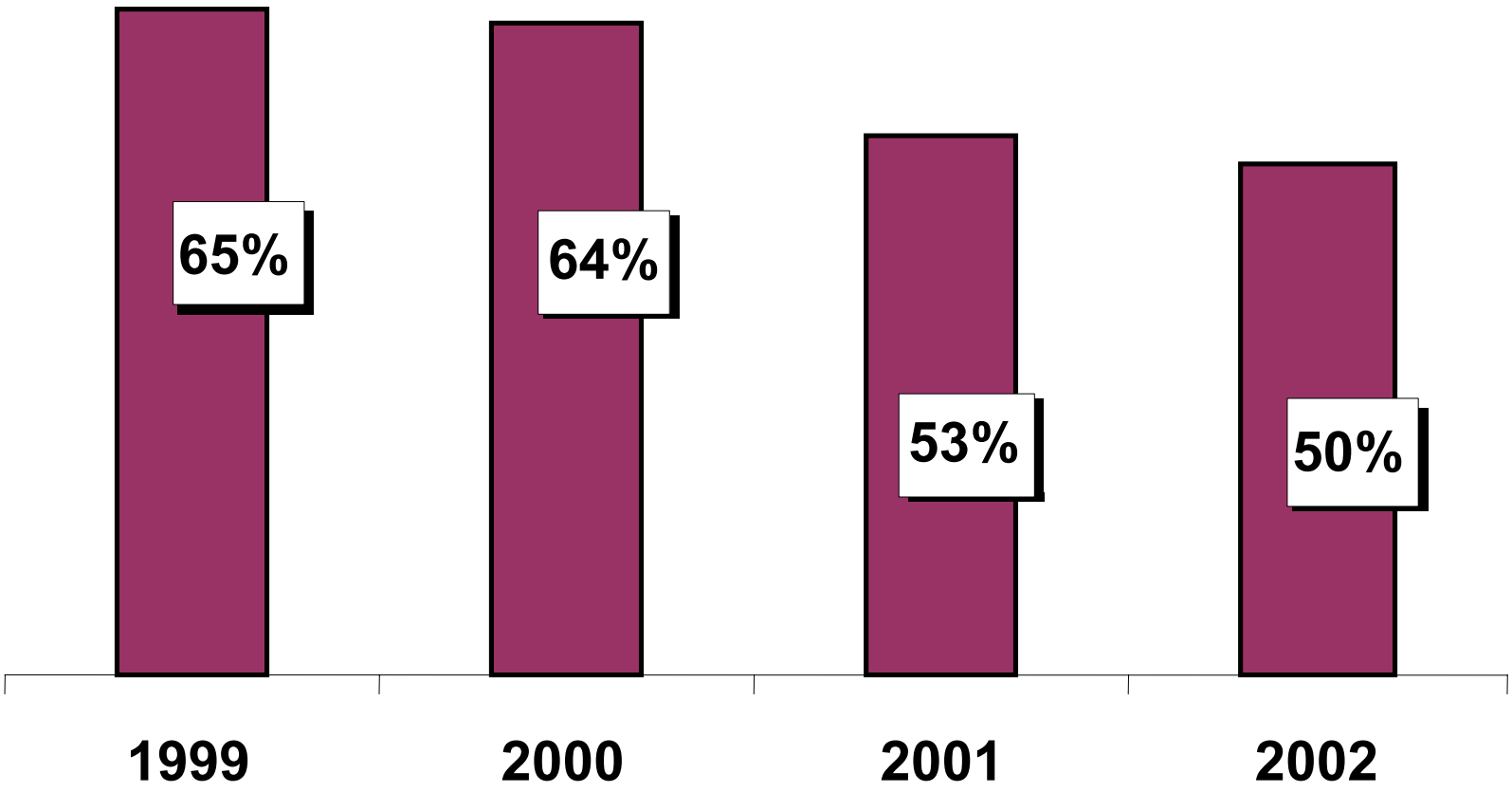


Year 2001 to 2002 Premiums

CMS CENTERS for MEDICARE & MEDICAID SERVICES

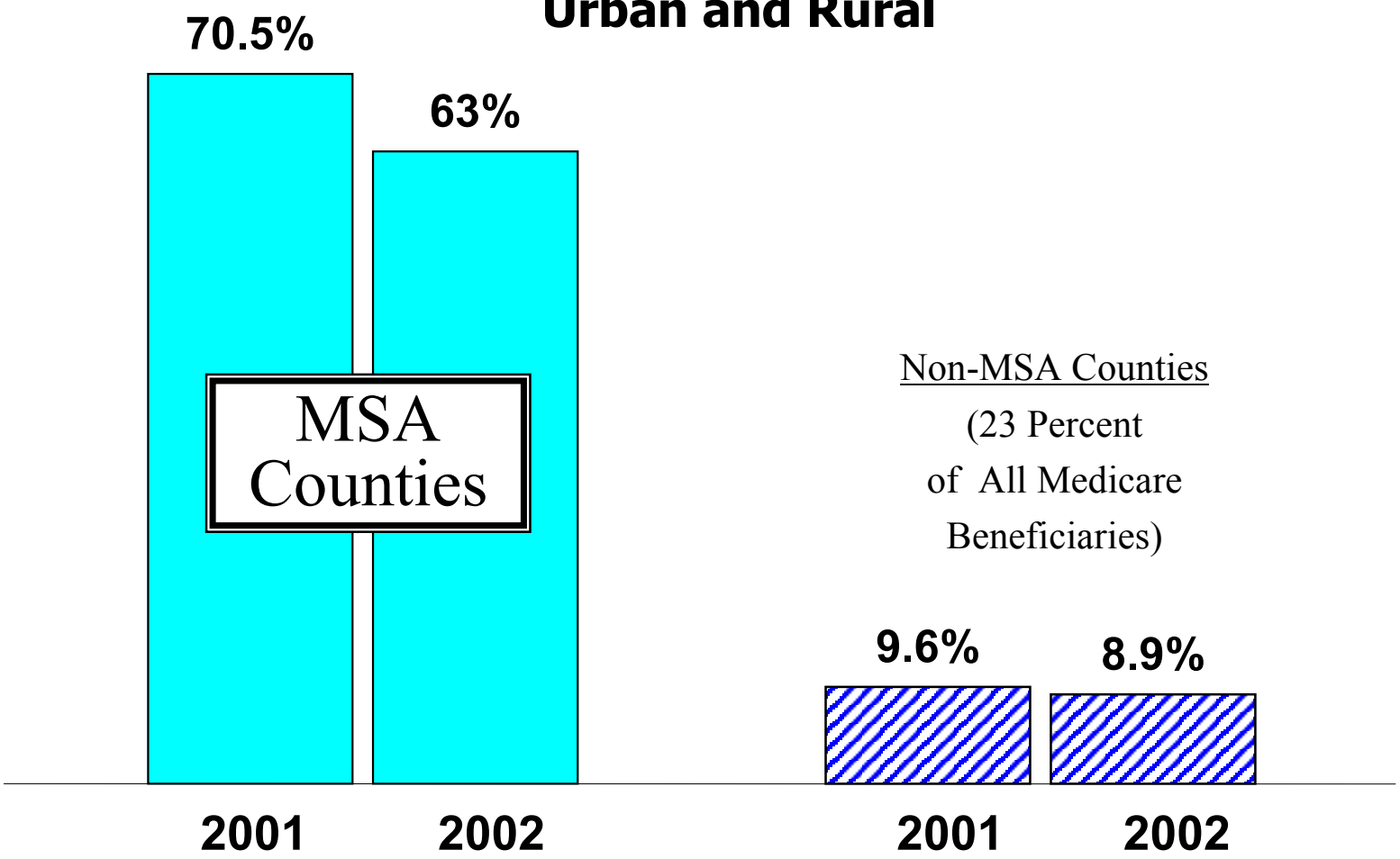
Access to an M+C CCP plan with drug coverage continues to decline, continuing the recent trend.

Percent of Total Medicare Population in US with Access to Any M+C Plan with Drug Coverage, 1999 to 2002



In urban areas, there will be a significant decline in the availability of M+C drug coverage.

Overall Medicare Population with Access to M+C Drug Coverage, Urban and Rural



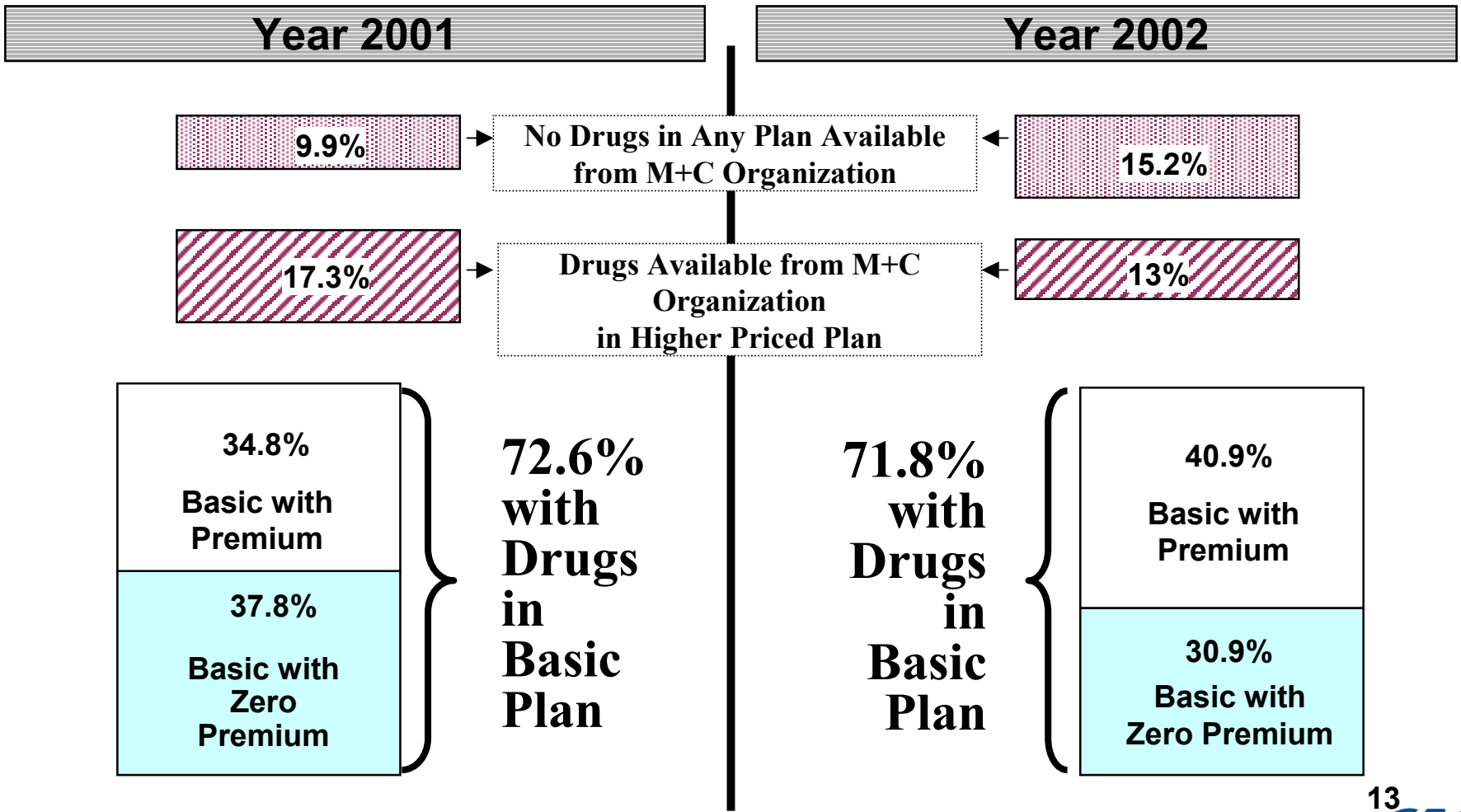
Three States (New Jersey, Illinois and Louisiana) will see significant declines in the availability of drug coverage for enrollees of M+C plans, though access to M+C will remain relatively stable in those States. One State (NC) will see a significant increase in drug access.

Changes in Drug Coverage Access, by State, March 2001 to 2002

STATE	Of Those with M+C CCP Available, % With Access to Drugs through M+C 3/2001	% With M+C Drug Access 2002	**% Point Change 2001 to 2002**	% With Any M+C CCP Access 3/2001	M+C CCP Access 2002	% Point Change 2001 to 2002
NJ	100%	1%	**-99%**	100%	100%	0%
IL	86%	10%	**-76%**	64%	58%	-6%
LA	100%	77%	**-23%**	49%	49%	0%
FL	97%	93%	**-4%**	76%	73%	-3%
MN	96%	95%	**-1%**	52%	52%	0%
29 States			**unchanged**			
7 States (NM, NY, OH, OR, SD, TN, WA)			**Increase of 2% to 15%**			
NC	0%	49%	**+49%**	47%	47%	0%

Most organizations will continue to provide drug coverage in their basic packages in 2002. However, the majority of organizations not providing such coverage are choosing not to make any type of drug coverage available to their enrollees.

Enrollment Distribution by Availability of Drug Coverage, Enrollees Unaffected by Non-Renewals, 2001 Versus 2002



Drug Offerings, 2001 to 2002

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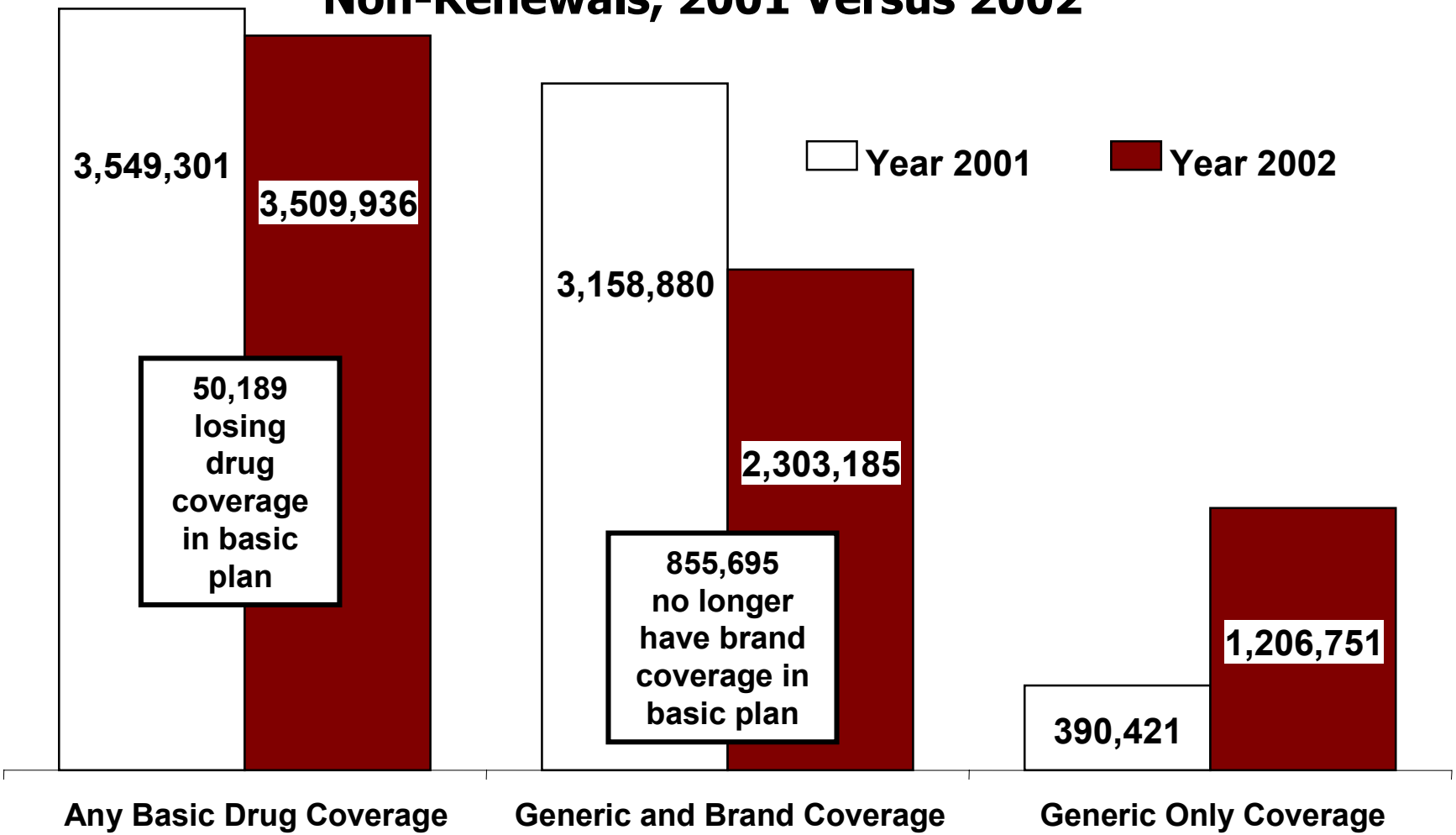
Brand-name drug coverage will decline sharply as more plans offer only generic drug coverage.

Enrollment by Type of Drug Coverage, Enrollees Unaffected by Non-Renewals, 2001 Versus 2002



Type of Drug Coverage, 2001 to 2002

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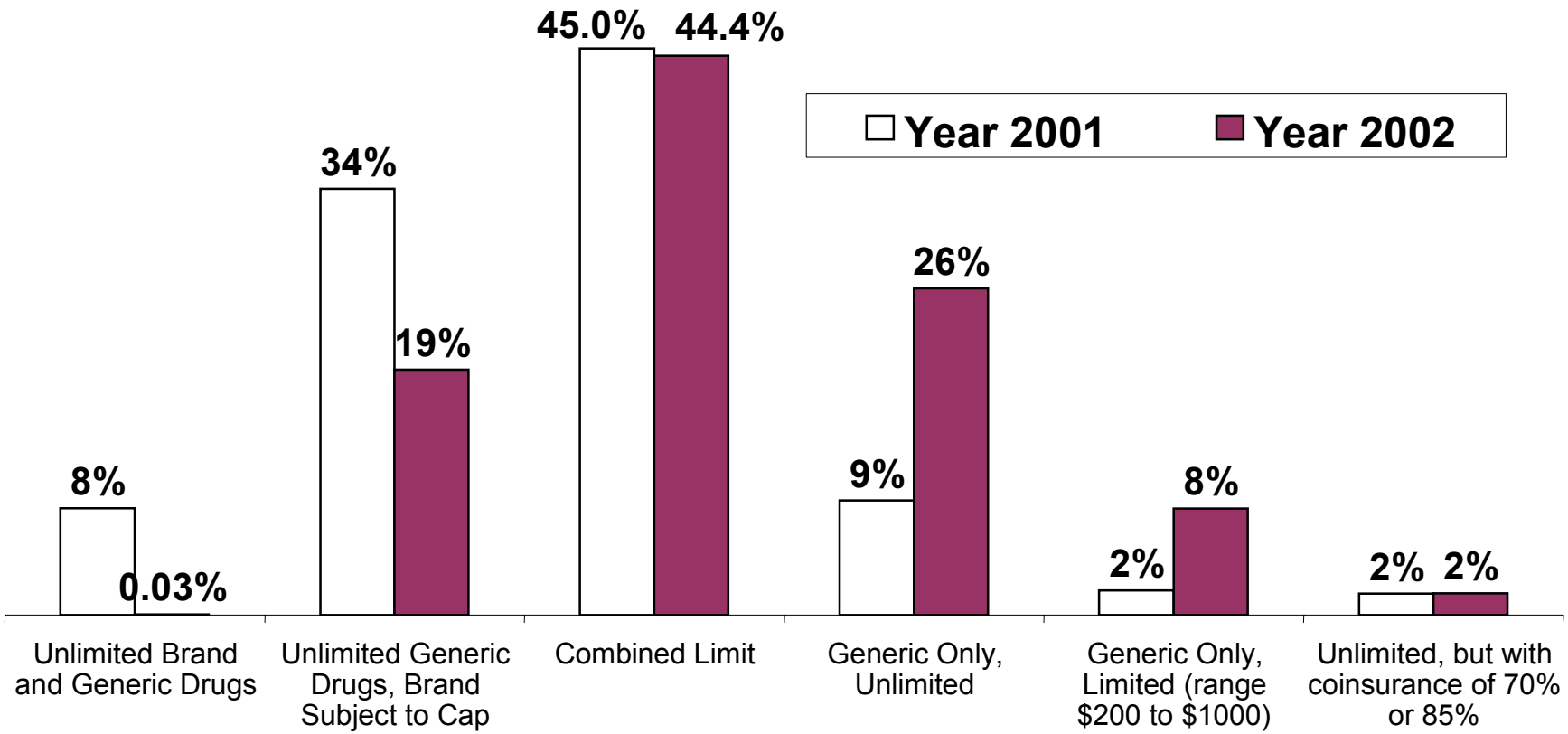
Unlimited brand-name drug coverage will virtually disappear, and unlimited generic coverage will become less common in 2002.

Distribution of Beneficiaries by Type of Drug Coverage, 2001 Versus 2002, Enrollees Unaffected by Non-Renewals



Type of Drug Coverage, Distribution 2001 to 2002

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Medicare+Choice (M+C) Non-Renewals at the End of 2001

For the contract year ending December 31, 2001, about 536,000 enrollees of M+C plans have been affected by non-renewals. That is, about 10 percent of current enrollees are affected by non-renewals, while 90% of enrollees are unaffected. About 90,000 of the affected enrollees will have no M+C coordinated care option available in their county in 2002. However, among the 90,000, about 52,000 will have access to an M+C private fee-for-service plan option.

Among "unaffected" enrollees, about 570,000 of the 4.8 million unaffected by non-renewals (about 12 percent of unaffected enrollees) are in a county in which there is only one remaining M+C coordinated care option. Hence, the large majority of enrollees in unaffected plans do have the opportunity to change plans.

Analysis of Benefit and Premium Changes

This analysis shows information about access to plans, access to zero premium coverage in M+C, and access to drug coverage. The access analyses are done at the level of the entire Medicare population of the United States. In examining access to drug coverage, any plan offered by an organization that includes coverage of outpatient prescription drugs not covered by Medicare is considered to constitute access to drug coverage. An organization may offer such coverage as part of a basic package in a county (the least costly package), or as an optional supplement or alternative, higher-priced option that enrollees may elect to buy.

For unaffected enrollees, their current benefits and premiums are shown. For 2002, the analysis shows what the premiums and benefits for this group will be if they remain in their current plans. Because 88 percent of the affected enrollees have the opportunity to enroll in a different M+C organization (if the organization does not have a capacity waiver that limits enrollment), the actual benefits and premiums of unaffected enrollees in 2002 may be different from what is shown here.

Notes About the Analysis

The analyses of benefits and premiums are based on Medicare Compare information (available from medicare.gov as a downloadable data base), and information extracted from the Health Plan Management System, the system that M+C organizations use to file benefit and rate information with CMS. The rate filings (the adjusted community rate (ACR) proposals) for 2002 used for this analysis were the filings as of September 25, 2001. A small number of enrollees (about one percent) are not included in the 2002 analyses because ACR information was not available as of September 25.

Most of the benefit and premium analyses are done on an enrollment-weighted or population-weighted basis. County-level enrollment is based on the county-level market penetration files (available at the CMS web site) or on similar files prepared for these analyses. Enrollees are included in the analysis only if they reside in a county that is part of the authorized service are of the M+C organization.

Historical information is based on Medicare Compare data, and ACR submissions, from earlier years. County-specific information became available in Medicare Compare in 1999. In 1998, the first year in which Medicare Compare was made available by CMS, Medicare risk organizations (entities that became M+C coordinated care plans in 1999) continued to offer "flexible benefit" options that varied by county. Users of Medicare Compare were often referred to the health plan for additional information about what types of benefits and premiums were offered in different counties. Hence, 1999 was the first year in which Medicare Compare provided detailed information on benefitsfor analyses that are enrollment- or population-weighted.

M+C enrollees enrolled in the plan through an employer-based or union-based retirement plan are likely to have more generous benefits than individual Medicare enrollees. In particular, the levels of drug coverage among M+C enrollees are likely to be understated in this analysis because of additional coverage that is available to some M+C enrollees.

Private Fee-for-Service Plan. The private fee-for-service plan is not a zero premium plan and does not offer drug coverage. It is therefore not included in these analyses except where noted.

Notes to Individual Slides

- **Slides 3-5, 10-12**. Access figures are for Medicare+Choice coordinated care plans (CCPs) and do not include the private fee-for-service plan or demonstration projects. For 2001 and 2002, population figures include Puerto Rico (where there is an available M+C CCP plan as of 2001) but not Guam and other territories. Access figures do not take into account capacity waivers (permitting plans to close enrollment in certain areas) or partial county coverage, which would reduce access numbers.

- **Slides 6 and 7**. Cost sharing values are based on premium and benefits proposals for 2002 submitted to CMS as of September 25, 2001. The values may change as these proposals are reviewed and approved or modified.

- **Slides 6-9, 13-15**. For year 2002 figures for enrollees unaffected by non-renewals at the end of 2001, it is assumed that enrollees will remain in their current plans. However, because about 90 percent of "unaffected" enrollees live in an area in which there will be more than one operating M+C CCP organization in 2002, actual premium and benefit distributions may be different from what is shown here. (Benefit information was unavailable for a small percentage of enrollees (about 11,000 in 2001 and fewer than 1.5% of enrollees in 2002). Premium and benefit information also excludes out-of-area enrollees (i.e., enrollees residing outside of the authorized service area of the organization).

- **Slide 10**. Data for years prior to 2002 are based on MedPAC analysis.

- **Slide 12**. In 2001, 31% of Arkansas residents had access to M+C, but no plans included drug coverage. There are no M+C CCP plans remaining in Arkansas for 2002.

- **Slide 14**. Figure for number of enrollees losing drug coverage is a net figure: 155,882 beneficiaries will be acquiring basic drug coverage; 206,071 will be losing basic drug coverage; and there are 10,824 out-of-area enrollees who appear to have drug coverage in 2001 who reside in counties that will be part of the CCP service area in 2002.

Terminology Used

- **Enrollment- or population-weighted:** *Values for numbers (such as premium or cost-sharing) averaged across all enrollees (beneficiaries) in proportion to their share of the total enrollment (population).*
- **Overall Medicare population:** *All Medicare beneficiaries in a geographic area, whether or not enrolled in M+C.*
- **Affected:** *Current M+C enrollees affected by a contract non-renewal, service area reduction, or partial county reduction at the end of 2001.*
- **Unaffected:** *Current M+C enrollees in organizations that are renewing their contracts for the service area in which the enrollees live.*
- **Basic plan:** *The lowest-cost, most generous (in benefits) plan offered by an M+C organization in a particular county.*
- **Cost sharing:** *Amounts paid by enrollees when they receive services, through copayments, deductibles, or cost sharing. Does not include premium amounts some M+C enrollees pay.*
- **Higher-priced plan:** *A plan offered by an M+C organization in a county which is more expensive than the organization's basic plan. For this analysis, the category also includes optional supplemental packages that an enrollee can add on to basic coverage.*
- **Drug coverage:** *Coverage of outpatient prescription drugs not covered by Medicare.*
- **Medicare-covered services portion of premium:** *Portion of the M+C premium that an enrollee pays that finances the organization's cost of providing Medicare-covered services. A total M+C premium may also include (or may only include) non-Medicare-covered services.*
- **MSA**: *Metropolitan Statistical Area. Counties within an MSA are considered urban counties.*